STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #81176.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 225	Continued From page 1	F 225		

certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 32 residents. Based upon record review and interviews the facility failed to report 2 allegations of verbal abuse (#9, #28) and failed to investigate an incident regarding a side rail to rule out abuse, neglect and exploitation for 1 resident (#27).

Findings included:

- Resident # 27's quarterly Minimum Data Set dated 12/28/14 identified the resident scored 3 on the Brief Interview for Mental Status, had delusions, hallucinations, displayed physical and behavior 1 to 3 days of the 7 day assessment period, wandered 4 to 6 of the 7 days in the assessment period. The MDS identified the resident required limited staff assistance with bed mobility, dressing, staff supervision with transfers, walking in the room/corridor, locomotion on/off the unit, limited assistance with dressing, and toilet use.

The resident's Fall Care Area Assessment (CAA) dated 7/3/14 documented the resident was at risk for falls due to use of medications.

The resident's care plan dated 1/20/15 addressed the resident was an elopement risk related to senile dementia with delusional features. The resident was disoriented to place and time and consistently asked to go home.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 225	Continued From page 2	F 225		

A nurse's note (NN) dated 1/9/2015 and timed 11:07 P.M. documented staff found the resident in another resident's room. The resident sat at a 90 degree angle, had crawled into the area the mattress normally sat if it was flat. The resident had one leg through the side rail from the inside and it took 20 minutes to get the resident out of the spot.

On 1/21/15 at 12:05 P.M. the resident ambulated independently in the dining room.

On 1/21/15 at 12:20 P.M. administrative nursing staff E stated he/she was not aware of the nurse note dated 1/9/15 and timed 11:07 P.M. He/she reviewed the nurse's note and stated staff should have informed him/her of the incident so he/she could have investigated how/what happened to see if it was a reportable event.

On 1/21/15 at 3:45 P.M. administrative nursing staff E stated from what he/she could tell from the nurse's note the resident tried to climb in bed with another resident and got his/her stuck in the side rail. Administrative nursing staff E stated he/she did not report the incident to the state agency.

On 1/21/15 at 4:05 P.M. administrative nursing staff E stated he/she spoke to the charge nurse on duty at the time of the incident and the nurse reported the resident went behind the resident's bed and got his/her her leg stuck between the bed frame and not the bed rail. He/she stated if the charge nurse had informed him/her of the incident at the time it occurred he/she would have investigated the incident.

On 1/21/15 at 4:15 P.M. observation revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

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F 225	Continued From page 3	F 225		

resident #16 (resident's bed resident #27 climbed in) laid in bed. Further observation revealed the head of the bed up approximately 90 degrees and (2) 1/4 side rails in place.

The facility failed to investigate the incident to rule out neglect.

- Resident #10's quarterly Minimum Data Set (MDS) 3.0 dated 11/5/14 identified the resident scored 6 (severely impaired cognition) on the Brief Interview for Mental Status, had no behaviors, required extensive staff assistance with bed mobility, dressing, toilet use and hygiene, was totally dependent upon staff for transfers, locomotion on/off the unit, the activity of walking in the room/corridor did not occur, required extensive staff assistance with dressing, toilet use and hygiene and required staff supervision with eating.

The resident's care plan dated 11/19/14 documented the resident had chronic confusion related to dementia. Staff identified himself/herself to the resident and addressed the resident by his/her preferred name. Staff used a calm approach, and attempted to address the resident's emotional needs. If the resident experienced agitation or confusion increased staff explored the psychological causes. The resident required extensive staff assistance with bath, dressing, personal hygiene, asked for staff assistance with toileting. The resident used a bedpan and staff assisted the resident with perineum care. Staff ensured the resident's call light was within reach when in his/her room unsupervised.

A concern/complaint referral form dated 12/4/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 4	F 225		

documented direct care staff V spoke harshly to residents. Resident #10's family member reported direct care staff V was angry with the call light the resident had and direct care staff V told the resident that he/she requested help too much and the he/she was too busy to keep coming into the resident's room all night.

On 1/20/15 at 1:41 P.M. the resident stated a night shift direct care staff (the resident provided the name of the staff) tells him/her that he/she utilized her call light requesting the bed pan too frequent. The resident stated the direct care staff gave him/her a hard time and it had going on for the last month or so. The resident stated he/she informed a family member of his/her concern.

On 1/26/15 at 10:00 A.M. the resident laid in bed and a family member was present. During interview with the resident at that time he/she stated the concern he/she expressed regarding the night shift staff on 1/20/15 continued. The family member stated he/she was aware of the resident's concern and the family had spoken to the facility regarding the statement(s) the direct care staff made to the resident regarding the use of the call light and the bed pan. The family member stated the comments from the direct care staff was unacceptable.

On 1/26/15 at 9:07 A.M. social service staff JJ stated he/she had spoken to nursing administrative staff E about the resident's concerns with the comments direct care staff V said to the resident regarding the use of the call light and requesting the bed pan. Social service staff JJ stated the resident's family member brought the concern to him/her. Social service staff JJ stated the resident stated direct care staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 5	F 225		

V was rude and rushed him/her.

On 1/26/15 at 9:17 A.M. administrative nursing staff E confirmed he/she was aware of the resident's concerns regarding direct care staff V. He/she stated the staff continued to work the night shift and he/she gave a verbal and written warning to direct care staff V. Administrative nursing staff E stated he/she did not obtain witness statements, did not speak to other residents, nursing staff members or the resident regarding the allegation. Administrative nursing staff E stated the allegation was not reported to the state agency.

The facility failed to thoroughly investigate an allegation of verbal abuse and failed to report the allegation to the state agency.

- Review of resident #9's (an unsampled resident) quarterly Minimum Data Set 3.0 dated 12/19/15 identified the resident scored 3 (severely impaired cognition), had delusions, physical behaviors 1 to 3 of the 7 day assessment period and verbal behaviors 4 to 6 days of the 7 day assessment period.

A concern/compliment referral form dated 12/24/14 documented direct care staff V spoke harshly to resident(s). Direct care staff V called resident #9 a "crazy old lady" to the resident's face. Corrective action taken included verbal coaching with direct care staff V.

On 1/26/15 at 9:17 A.M. administrative nursing staff E confirmed he/she was not aware of the resident's concerns regarding direct care staff V. He/she stated the staff continued to work the night shift and he/she gave a verbal and written

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

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F 225	Continued From page 6 warning to direct care staff V. Administrative nursing staff E stated he/she did not obtain witness statements, did not speak to other residents, nursing staff members or the resident regarding the allegation. Administrative nursing staff E stated the allegation was not reported to the state agency. The facility failed to thoroughly investigate an allegation of verbal abuse and failed to report the allegation to the state agency.	F 225		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: The facility had a census of 32 residents. The sample included 12 residents. Based upon observation, record review and interview the facility failed to care for 1 (#10) resident in a manner that maintained or enhanced his/her dignity. Findings included: - Resident #10's quarterly Minimum Data Set (MDS) 3.0 dated 11/5/14 identified the resident scored 6 (severely impaired cognition) on the Brief Interview for Mental Status, had no behaviors, required extensive staff assistance with bed mobility, dressing, toilet use and hygiene, was totally dependent upon staff for	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

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F 241	Continued From page 7	F 241		

transfers, locomotion on/off the unit, the activity of walking in the room/corridor did not occur, required extensive staff assistance with dressing, toilet use and hygiene and required staff supervision with eating.

The resident's care plan dated 11/19/14 documented the resident had chronic confusion related to dementia. Staff identified himself/herself to the resident and addressed the resident by his/her preferred name. Staff used a calm approach, and attempted to address the resident's emotional needs. If the resident agitation or confusion increased staff explored the psychological causes. The resident required extensive staff assistance with bath, dressing, personal hygiene, asked for staff assistance with toileting. The resident used a bedpan and staff assisted the resident with perineum care. Staff ensured the resident's call light was within reach when in his/her room unsupervised.

A nurse's note (NN) dated 9/13/2014 and timed 4:29 A.M. documented the resident was awake most of the night turning on his/her call light and stated his/her knees hurt.

A NN dated 9/23/2014 and timed 9:22 A.M. included administrative staff and the resident's family discussed a concern the resident had regarding the care provided by a direct care staff. Staff explained the facility would do their best to allow other direct care staff to care for the resident rather; however at times there may not be a choice and the direct care staff the resident expressed concern about would have to provide care for the resident.

A NN dated 11/3/2014 and timed 1:46 A.M.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

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F 241	Continued From page 8	F 241		

documented the resident was continuously on the call light requesting the bed pan.

A concern/complaint referral form dated 12/4/14 documented direct care staff V spoke harshly to residents. Resident #10's family member reported direct care staff V was angry with the all light the resident had and direct care staff V told the resident that he/she requested help too much and the he/she was too busy to keep coming into the resident's room all night.

On 1/20/15 at 1:41 P.M. the resident stated a night shift direct care staff (the resident provided the name of the staff) tells him/her that he/she utilized her call light requesting the bed pan too frequent. The resident stated the direct care staff gave him/her a hard time and it had going on for the last month or so. The resident stated he/she informed a family member of his/her concern.

On 1/26/15 at 10:00 A.M. the resident laid in bed and a family member was present. During interview with the resident at that time he/she stated the concern he/she expressed regarding the night shift staff on 1/20/15 continued. The family member stated he/she was aware of the resident's concern and the family had spoken to the facility regarding the statement(s) the direct care staff made to the resident regarding the use of the call light and the bed pan. The family member stated the comments from the direct care staff was unacceptable.

On 1/26/15 at 9:07 A.M. social service staff JJ stated he/she had spoken to nursing administrative staff E about the resident's concerns with the comments direct care staff V said to the resident regarding the use of the call

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

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F 241	Continued From page 9 light and requesting the bed pan. Social service staff JJ stated the resident's family member brought the concern to him/her. Social service staff JJ stated the resident stated direct care staff V was rude and rushed him/her. On 1/26/15 at 9:17 A.M. administrative nursing staff E confirmed he/she was aware of the resident's concerns regarding direct care staff V. He/she stated the staff continued to work the night shift and he/she gave a verbal and written warning to direct care staff V. The facility failed to ensure that this resident was treated in a manner that promoted or enhanced his/her dignity.	F 241		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 10	F 278		

willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 32 residents. The sampled included 12 residents. Based on observation, record review, and interview the facility failed to ensure accuracy of the Minimum Data Set (MDS) for 2 (#26, #33) of the sampled residents.

Findings included:

- The quarterly Minimum Data Set (MDS) dated 8/22/14 for resident #26 revealed a Brief Interview for Mental Status (BIMS) score of 2, indicating severe cognitive impairment. The resident had one stage 2 pressure ulcer noted.

The quarterly MDS dated 11/22/14 for the resident revealed a BIMS score of 4, indicating severe cognitive impairment. The assessment showed the resident did not have any pressure ulcers present on the previous assessment.

Observation on 1/21/15 at 11:11 A.M. revealed the resident rested quietly in bed with his/her eyes closed.

Interview on 1/26/15 at 11:05 A.M. with licensed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 11	F 278		

nursing staff J revealed the MDS coordinator completed the assessments and staff J expected them to be accurate for the resident.

Interview on 1/26/15 at 12:09 P.M. with administrative nursing staff E revealed he/she acknowledged the 11/22/14 MDS showed there was no pressure ulcer present on the 8/22/14 MDS, which was incorrect. Staff E expected the MDS to be accurate for each resident.

The policy provided by the facility with a revision date of October 2010 regarding the Resident Assessment Instrument revealed the signatures on the MDS attest the accuracy of the information.

The facility failed to ensure accuracy for the MDS of this severely cognitively impaired resident who had a pressure wound at the time of these assessments.

- The admission Minimum Data Set (MDS) dated 10/28/14 for resident #33 revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating no cognitive impairment. The resident was noted to have an external catheter.

Review of the nurse's notes from 10/15/14 at 5:00 P.M. through 10/31/14 at 3:32 P.M. lacked evidence the resident had any type of catheter.

Observation on 1/21/15 at 11:56 A.M. revealed the resident sat in a wheelchair at a table in the dining room, feeding him/herself independently and conversing with other residents.

Interview on 1/26/15 at 10:00 A.M. with direct care staff W revealed he/she did not recall the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

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F 278	Continued From page 12 resident ever having any type of catheter since admitting to the facility. Interview on 1/26/15 at 10:40 A.M. with administrative nursing staff D revealed he/she did not believe the resident ever had an external catheter. Staff E expected the MDS to be accurate for each resident. Interview on 1/26/15 at 12:09 P.M. with administrative nursing staff E revealed this resident did not have a catheter upon admission to the facility. Staff E acknowledged the MDS was inaccurate for this resident. The policy provided by the facility with a revision date of October 2010 regarding the Resident Assessment Instrument revealed the signatures on the MDS attest the accuracy of the information. The facility failed to ensure accuracy for the MDS of this resident.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 13	F 279		

to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 32 residents. The sample included 12 residents. Based on observation, record review, and interview the facility failed to develop an individualized, comprehensive care plan regarding hospice services and pressure ulcer care for 1 (#7) of the sampled residents.

Findings included:

- The admission Minimum Data Set (MDS) dated 1/8/15 for resident #7 revealed a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. He/she required extensive assistance from 2 or more staff for bed mobility, dressing, toilet use, and personal hygiene. The resident was dependent on staff for transferring and bathing. His/her weight was 140 pounds (#) and he/she received a mechanically altered diet. He/she had a prognosis of 6 months or less and had 5 stage 1 pressure ulcers, 1 stage 2 pressure ulcer, 1 stage 3 pressure ulcer, 1 stage 4 pressure ulcer, and 4 unstageable pressure ulcers.

The 1/9/15 Care Area Assessment (CAA) regarding cognitive loss and dementia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 14	F 279		

(progressive mental disorder characterized by failing memory, confusion) revealed the resident had a diagnosis of dementia, received hospice services, had a hip fracture, and had documented refusal of medications, treatments, and wound dressings.

The 1/9/15 CAA regarding pressure ulcers revealed assessment of the resident's skin reflected 12 skin issues ranging from stage 1 to unstageable. Staff provided a pressure relieving mattress. Due to the resident being on hospice, staff predicted a gradual decline in condition but planned to minimize risks and not increase the severity of his/her wounds.

The 1/9/15 CAA regarding nutrition revealed the resident had extensive skin issues and staff were going to refer him/her to the dietitian to determine if hydration and/or supplements could improve his/her skin condition.

The comprehensive care plan with a revision date of 1/15/15 revealed the resident had actual impairment to skin integrity related to inadequate dietary intake and limited physical mobility. The care plan lacked documentation of develop or implementation of interventions for skin care. The care plan also revealed the resident was receiving hospice services but failed to show what disciplines visited the resident, the frequency of the visits, what services would be provided by the hospice team, and what equipment they provided.

Observation on 1/22/15 at 2:07 P.M. revealed licensed nurse I and licensed nurse K performed wound care for the resident. Staff washed their hands, applied gloves, then used normal saline

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 15	F 279		

and a 4 by 4 gauze to clean with right inner foot wound, then applied Santyl (debriding ointment) to the wound bed, wrapped the foot with gauze, and secured it with paper tape. The wound was covered with slough and surrounding skin appeared pink/red. Staff changed gloves then cleansed the inner right knee wound with normal saline then covered it with an Allyven dressing. The surrounding skin appeared pink. Staff checked the placement of the dressing on the resident's sacrum and it was dry and intact. Throughout the procedure the resident scratched at his/her legs and attempted to kick off heel protectors. Staff replaced bilateral heel protectors prior to leaving the room.

Interview on 1/22/15 at 3:53 P.M. with direct care staff P revealed the resident received hospice services. He/she knew a nurse and an aide visited the resident but was unsure of the frequency. Staff P was unsure if the information was on the resident's care plan.

Interview on 1/26/15 at 11:05 A.M. with licensed nursing staff J revealed he/she was new to the facility and unsure if the nurse developed the comprehensive care plan but knew the nursing staff was able to revise the care plan as needed. Staff J expected the care plan to be individualized for hospice care and for skin care due to him/her having such extensive skin concerns. Staff J thought the care plan should include what disciplines visit for hospice services.

Interview on 1/26/15 at 12:09 P.M. with administrative nursing staff E revealed a care plan team developed the comprehensive care plans. The team included social services, the activity director, the quality assurance nurse, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 16 director of nursing, and intermittently a direct care staff member. Staff E reported the team aimed to make the care plans individualized for each resident and to include resident preferences. Staff E acknowledged the care plan lacked individualization for hospice services and failed to show any interventions regarding skin care. The policy provided by the facility with a revision date of October 2010 regarding comprehensive care plan revealed an individualized comprehensive care plan that included measurable objectives and timetables to meet the resident's medical, nursing, mental, and psychological needs was developed for each resident. The facility failed to develop an individualized comprehensive care plan regarding hospice services and wound care for this severely cognitively impaired resident with 12 pressure ulcers who received hospice services.	F 279		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: The facility had a census of 32 residents. The sample included 12 residents. Based upon observation, record review and interview the facility failed to consistently bath/shower 1 (#1)	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 17	F 312		

resident to maintain personal hygiene and failed to provide assistance to 1 (#28) resident with eating.

Findings included:

- Resident #1's quarterly Minimum Data Set (MDS) 3.0 dated 1/11/15 identified the resident scored 3 (severely impaired cognition) on the Brief Interview for Mental Status and had delusions. The resident required limited staff assistance with bed mobility, transfers, walking in the room, personal hygiene, extensive staff assistance with walking in the corridor, dressing, supervision with locomotion on/off the unit, eating, extensive staff assistance with dressing, toilet use and the activity of bathing did not occur during the 7 day assessment period.

The resident's Activity of Daily Living Care Area Assessment (CAA) dated 7/23/14 included the resident was forgetful.

The resident's care plan dated 10/29/14 addressed the resident had a self care deficit as evident by decreased mobility and cognition secondary to mood alteration. Staff encouraged the resident to perform his/her bathing, grooming and oral care as able with set-up help.
The resident's care plan did not address the resident's bathing schedule or interventions if the resident refused showers.
A nurse's note (NN) dated 10/4/2014 timed 2:30 P.M. documented the resident refused his/her showers that week. The resident stated he/she preferred evening showers as he/she did not like the feeling of having his/her hair wet all day long. The resident also stated the shampoo/soap was too harsh.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 18	F 312		

Review of the resident's November 2014 documentation survey report lacked evidence to support the resident received a shower during the month of November 2014. The report did not document the resident had refused showers/baths.
The residents December 2014 documentation survey report documented the resident received a bath/shower on 12/13/14 at 12:16 P.M. The documentation lacked evidence to support the resident received another bath/shower during the month of December 2014. Documentation on the report included the resident preferred his/her shower in the evenings. The report did not document the resident had refused showers/baths.
Review of the the resident's January documentation survey report on 1/22/15 at 10:00 A.M. documented the resident received a bath/shower on 1/21/15 at 1:59 P.M. The documentation lacked evidence to support the resident had received a bath/shower from 1/1/5 until the bath/shower documented on 1/22/15. Documentation on the report included the resident preferred his/her shower in the evening. The report did not document the resident had refused showers/baths.
On 1/26/15 at 12:15 P.M. the resident wheeled himself/herself down the hallway.
On 1/20/15 at 11:40 A.M. the resident stated he/she barely received a shower once a shower.
On 1/22/15 at 3:49 P.M. direct care staff P stated some days the resident wanted his/her shower before dinner and on some days he/she wanted a bath after dinner. Direct care staff P stated unless otherwise requested residents received two baths a week.

On 1/26/15 at 11:19 A.M. administrative nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 19	F 312		

staff E confirmed the documentation on the documentation survey report. He/she stated there was no other bathing documentation. Administrative nursing staff E stated resident received a shower at least twice a week.

The facility failed to ensure this resident received showers/baths in order to maintain his/her personal hygiene.

- Resident #28's diagnoses list included the resident had a diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) without behavioral disturbances, and a traumatic brain injury (brain injury caused by sudden damage to the brain).

The resident's quarterly Minimum Data Set (MDS) 3.0 dated 12/25/14 identified the resident scored 01 (severely impaired cognition) on the Brief Interview for Mental Status, and had verbal behaviors 1 to 3 days of the 7 day assessment period. The MDS identified the resident required limited staff assistance with bed mobility, dressing, toilet use and personal hygiene, required staff supervision with transfers, was independent with walking in the room/corridor and locomotion on/off the unit and required extensive staff assistance with eating. The MDS identified the resident had a loss of liquids/solids from his/her mouth when eating or drinking, held food in his/her mouth/cheeks or residual food in his/her mouth after meals, and had experienced coughing or choking during meals or when swallowing medications during the 7 day assessment period.

The resident's Cognitive Loss/Dementia Care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 20	F 312		

Area Assessment (CAA) dated 3/25/14 included the resident misperceived when staff attempted to assist him/her and attempted to hit and bite staff.

The resident's care plan dated 1/15/14 included staff observed the resident during eating and reported difficulty with chewing/swallowing to the charge nurse. The resident ate independently without adaptive devices and the resident pocketed food at times.

On 1/21/15 at 11:15 A.M. the resident sat on the sofa and appeared asleep. The resident's mouth was slightly open and food particles were observed on the resident's tongue.

On 1/21/15 at 12:10 P.M. the resident sat on the sofa and appeared asleep. Observation revealed the resident's mouth was open, and food came out of the right side of the resident's mouth.

On 1/21/15 at 1:05 P.M. the resident sat at a table in the dining room and received his/her lunch meal which consisted of a taco salad, rice, and pears with a topping.

On 1/21/15 at 1:10 P.M. the resident placed the taco meat on the fork with his/her hand.

On 1/21/15 at 1:30 P.M. observation revealed the resident had difficulty manueving the taco meat and chips on the fork. Further observation revealed no staff assisted the resident.

On 1/21/15 at 2:00 P.M. the resident placed the taco meat with chips on the fork with his/her finger, placed the fork to his/her mouth and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 21	F 312		

chips fell into the plate. Observation revealed the resident did not have adaptive equipment and no staff assisted the resident. Observation revealed food on the the resident's clothing.

On 1/22/15 at 7:45 A.M. the resident ate the breakfast meal which consisted of sausage gravy and biscuit and scrambled eggs.

On 1/22/15 at 8:25 A.M. the resident had consumed almost all of sausage gravy and biscuit and 5 percent (%) of the scrambled egg. The resident attempted to place the sausage gravy and the biscuit on the fork. Observation revealed the resident pushed the food away from him/her while attempted to place the food on the fork. The surveyor pointed to the spoon and asked the resident if he/she thought the spoon would help. The resident picked up the spoon and was able to place the food items on the spoon without difficulty. The resident used the spoon to consume 100% of the eggs. Observation revealed no staff assisted the resident with the meal and the resident did not have adaptive utensils.

On 1/27/14 at 3:05 P.m. direct care staff P stated the resident ate independently and did not use adaptive equipment during meals.

On 1/26/15 at 1:56 P.M. licensed nurse H stated the resident ate independently. He/she stated the resident had some spillage during meals during to shaking while eating.
On 1/26/15 at 3:16 P.M. administrative nursing staff E stated the resident was able to eat without staff assistance. He/she stated the resident usually used his/her hands to eat and food particles were often times on the resident's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 22 clothing. Administrative nursing staff E stated he/she had worked at the facility since 8/2014 and the facility had not evaluated the resident for adaptive equipment during meals. The facility failed to assist this resident during meals who was assessed to require extensive staff assistance with eating. The facility failed to evaluate to see if the resident would benefit from adaptive dining equipment/utensils.	F 312		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: The facility identified a census of 32 residents. The sample included 12 residents. Based on observation, record review, and interview the facility failed to develop and implement tinely and appropriate interventions to promote healing and prevent new or worsening of pressure sores for 1 (#7) of 1 resident sampled with pressure ulcers. the facility also failed to have a skin care plan in place for 17 days when he/she admitted to the facility with multiple wounds. The resident developed additional unstageable wounds after admission.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 23	F 314		

Findings included:

- The admission Minimum Data Set (MDS) dated 1/8/15 for resident #7 revealed a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. He/she required extensive assistance from 2 or more staff for bed mobility, dressing, toilet use, and personal hygiene. The resident was dependent on staff for transferring and bathing. He/she had a prognosis of 6 months or less and had 5 stage 1 pressure ulcers, 1 stage 2 pressure ulcer, 1 stage 3 pressure ulcer, 1 stage 4 pressure ulcer, and 4 unstageable pressure ulcers.

The 1/9/15 Care Area Assessment (CAA) regarding cognitive loss and dementia (progressive mental disorder characterized by failing memory, confusion) revealed the resident had a diagnosis of dementia, received hospice services, had a hip fracture, and had documented refusal of medications, treatments, and wound dressings.

The 1/9/15 CAA regarding nutrition revealed the resident had extensive skin issues and staff were going to refer him/her to the dietitian to determine if hydration and/or supplements could improve his/her skin condition.

The 1/9/15 CAA regarding pressure ulcers revealed assessment of the resident's skin reflected 12 skin issues ranging from stage 1 to unstageable. Staff provided a pressure relieving mattress. Due to the resident being on hospice, staff predicted a gradual decline in condition but planned to minimize risks and not increase the severity of his/her wounds.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 24	F 314		

The interim care plan dated 12/29/14 revealed the resident had impaired skin integrity but lacked interventions.

The comprehensive care plan with a revision date of 1/15/15 revealed the resident had actual impairment to skin integrity related to inadequate dietary intake and limited physical mobility. Staff provided the resident with repositioning every 2 hours. The care plan lacked evidence of treatments for and description of his/her wounds or location.

The admitting nursing assessment and history dated 12/29/14 revealed the resident weighed 147.7 pounds (#) upon admission and had the following wounds, descriptions, and measurements:
- Left buttock, pressure, 2.5 centimeters (cm) by (x) 2.5 cm
- Right antecubital, bruising, 3.0 cm x 7.5 cm
- Right lower arm, bruising, 4.5 cm x 4.0 cm
- Right lower arm, 2 pinpoint sores
- R trochanter (hip), 10 staples from surgery
- Groin, red
- Right foot outside, pressure, 2.0 cm x 1.2 cm
- Right foot bunion area, pressure, 2.4 cm x 1.9 cm
- Right heel, boggy
- Left heel, boggy
"Continued on skin assessment"

The skin observations tool dated 12/30/14 revealed the following wounds, descriptions, and measurements:
- Left foot bunion area, pressure, 0.5 cm x 0.5 cm
- Left inner ankle, pressure, 3.0 cm x 2.5 cm
- Left heel, red and boggy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 25	F 314		

- Left great toe, several fluid filled
- Left foot outside, pressure, 2.5 cm x 2.5 cm
- Left inner ankle, pressure necrotic (pertaining to the death of tissue in response to disease or injury), 1.4 cm x 1.4 cm
- Right inside knee, pressure, 2.5 cm x 2.5 cm

The skin observation tool dated 1/1/15 revealed the resident had no skin issues noted at that time.

The weekly pressure ulcer healing assessment sheets dated 1/5/15 had a place to number each wound but the form lacked documentation of a number associated with each wound. The forms revealed the following wounds, descriptions, and measurements:
- Left upper buttock/sacrum, Stage 2, wound bed epithelium, no drainage, no undermining, wound edges intact, surrounding skin intact, 7.0 cm x 6.0 cm, Notes: Allevyn (type of wound dressing) to area, date of onset: admission (increased in size from 2.5 cm x 2.5 cm)
- Right outer foot, Unstageable, Eschar (dead tissue) in wound bed, no drainage, no undermining, wound edges intact, surrounding skin intact, 1 cm x 1 cm, date of onset: admission
- Left heel, Unstageable, Eschar in wound bed, wound edges intact, surrounding skin intact, 6 cm x 5 cm, Notes: necrotic tissue, date of onset: admission (increased in size from admission)
- Right heel, Unstageable, no undermining, no drainage, rolled wound edges, surrounding skin dark red and intact, 8 cm x 6 cm, Notes: fluid filled with necrotic tissue, date of onset: admission (increased in size from admission)
- Left great toe - bunion, Stage 1, no undermining, no drainage, wound edges intact, surrounding skin intact and pink/red, 3 cm x 3 cm, Notes: redness to bony area, date of onset:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 26	F 314		

admission (increased in size from admission)
- Right great toe, Stage 4, Slough (dead tissue, usually cream or yellow in color) in the wound bed, no undermining, no drainage, wound edges were red and hard or had induration, surrounding skin intact and dark red, 2 cm x 2 cm, Notes: Slough - tissue exposure, date of onset: admission (not documented previously)
- Right inner knee, Stage 3, slough in wound bed, no undermining, no drainage, wound edges hard or had induration, surrounding skin intact, 2.5 cm x 1.2 cm, Notes: slough center, date of onset: admission
- Left outer ankle, Unstageable, eschar in wound bed, no undermining, no drainage, wound edges intact, surrounding skin red, 4 cm x 6 cm, Notes: necrotic tissue, date of onset: admission (not documented previously)
- Left little toe outer, Stage 1, epithelial tissue in wound bed, no undermining, no drainage, wound edges intact, surrounding skin intact and dark red, 0.3 cm x 0.6 cm, date of onset: admission (not previously documented)
- Right upper inner ankle, Stage 1, no undermining, no drainage, wound edges intact, surrounding skin intact and dark red, 0.5 cm, Notes: Reddened area, date of onset: admission (not previously documented)
- Right inner ankle, Stage 1, no undermining, no drainage, wound edges intact, surrounding skin intact and dark red, 2 cm x 2 cm, Notes: Pink tissue with no opening, date of onset: admission (not previously documented)
- Right inner mid-foot, Stage 1, no undermining, no drainage, wound edges intact, surrounding skin intact, 1.2 cm x 1 cm, Notes: Reddened and no opening, date of onset: admission (not previously documented)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 27	F 314		

The Skin observation tool dated 1/8/15 revealed the following wounds, descriptions, and measurements:
- Right toes, 2 cm x 2 cm, Stage 4
- Left toes, 0.3 cm x 0.6 cm, Stage 1
- Right ankle outer, 1 cm x 1 cm, Unstageable
- Left heel, 6 cm x 5 cm, Unstageable
- Right inner upper ankle, 0.5 cm x 0.5 cm, Stage 1
- Right heel, 8 cm x 6 cm, Unstageable
- Right inner mid foot, 1.2 cm x 1 cm, Stage 1
- Right ankle inner, 2 cm x 2 cm, Stage 1
- Sacrum, 7 cm x 6 cm, Stage 2
- Left ankle outer, 4 cm x 6 cm, Unstageable
- Left toes, 3 cm x 3 cm, Stage 1
- Right inner knee, 2.5 cm x 1.2 cm, Stage 3

The weekly pressure ulcer healing assessment sheets dated 1/15/15 had a place to number each wound but the form lacked documentation of a number associated with each wound. The forms revealed the following wounds, descriptions, and measurements:
- Left upper buttock/sacrum, Stage 2, wound bed epithelium, no drainage, no undermining, wound edges intact, surrounding skin intact, 6 cm x 4 cm, date of onset: admission
- Right outer foot, Unstageable, Eschar in wound bed, no drainage, no undermining, wound edges intact, surrounding skin intact, 1 cm x 1 cm, date of onset: admission
- Left heel, Unstageable, Eschar in wound bed, wound edges intact, surrounding skin intact, 5.9 cm x 4.7 cm, date of onset: admission
- Right heel, Unstageable, no undermining, no drainage, rolled wound edges, surrounding skin dark red and intact, 8 cm x 5 cm, date of onset: admission
- Left great toe - bunion, Stage 1, no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 28	F 314		

undermining, no drainage, wound edges intact, surrounding skin intact and pink/red, 3 cm x 3 cm, Notes: redness, date of onset: admission
- Right great toe, Stage 4, Slough in the wound bed, no undermining, no drainage, wound edges were red and hard or had induration, surrounding skin intact and dark red, 2 cm x 2 cm, Notes: no change, date of onset: admission
- Right inner knee, Stage 3, slough in wound bed, no undermining, no drainage, wound edges hard or had induration, surrounding skin intact, 2.4 cm x 1.2 cm, Notes: no change, date of onset: admission
- Left outer ankle, Unstageable, eschar in wound bed, no undermining, no drainage, wound edges intact, surrounding skin red, 3.8 cm x 5.8 cm, date of onset: admission
- Left little toe outer, Stage 1, epithelial tissue in wound bed, no undermining, no drainage, wound edges intact, surrounding skin intact and dark red, 0.4 cm x 0.7 cm, date of onset: admission
- Right upper inner ankle, Stage 1, no undermining, no drainage, wound edges intact, surrounding skin intact and dark red, 0.6 cm, date of onset: admission
- Right inner ankle, Stage 1, no undermining, no drainage, wound edges intact, surrounding skin intact and dark red, 2 cm x 2 cm, date of onset: admission
- Right inner mid-foot, Stage 1, no undermining, no drainage, wound edges intact, surrounding skin intact, 1.3 cm x 1 cm, Notes: Reddened and no opening, date of onset: admission

The above skin assessments were not thorough and lacked consistent assessment with measurements making it difficult to determine what was actually present on admission and if the wounds worsened or improved.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 29	F 314		

The 12/31/14 laboratory results revealed an albumin level (blood test used to measure the amount of protein in the blood, used in part to determine a person's nutritional status) was low at 3.2 and the desirable range was 3.5 to (-) 5.2. His/her total protein level was low at 6.2 and the desirable range was 6.6 - 8.7.

Review of the clinical record revealed only one note from the dietitian: The 1/21/15 at 5:43 P.M. nutrition note revealed the resident weighed 122.2# and his/her previous weight was 140#, noting a 17# weight loss recently. The note showed he/she had decreased intake and appetite with weakness and a recent fall. The resident's diet was regular with mechanical soft texture and staff encouraged fluids. The note also revealed the resident's skin was intact, told the reader to refer to nursing, and showed the resident had a fracture of the hip previously noted in the medical record. Medications were reviewed and he/she may benefit from supplement for increased nutrition needs. The dietitian recommended Ensure Plus twice a day at med pass. Staff were to continue with the plan of care, check weights weekly, and monitor as needed.

Review of the clinical record revealed the following weights:
12/29/14 equaled (=) 147.7#
1/8/15 = 140.0#
1/20/15 = 122.2# (a 17.3% loss since admission)
1/25/15 = 116.8#

Review of the January 2015 Medication and Treatment Administration Record (MAR/TAR) on 1/26/15 at 7:17 A.M. lacked documentation showing staff provided the resident with Ensure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 30	F 314		

Plus twice a day since the dietitian recommended per the 1/21/14 at 5:43 P.M. note.

Observation on 1/22/15 at 8:25 A.M. revealed the resident sat in a broda chair at a table in the dining room and received eggs, biscuits and gravy, oatmeal, grape juice, milk, and water. The resident was able to eat and drink with intermittent cueing from staff. At 8:45 A.M. the staff left the table and the resident sat quietly. He/she consumed approximately 5-10% of the meal. At 9:10 A.M. 3 staff members returned to table but did not engage in conversation with the resident. The resident sat in his/her broda chair quietly with his/her eyes closed until 9:26 A.M. when direct care staff Q propelled the resident from the dining room to his/her room, locked the brakes, placed the call light in reach, and exited the room. Staff failed to give verbal encouragement or offer alternative foods.

Observation on 1/22/15 at 2:07 P.M. revealed licensed nurse I and licensed nurse K performed wound care for the resident. Staff washed their hands, applied gloves, then used normal saline and a 4 by 4 guaze to clean with right inner foot wound, then applied Santyl (debriding ointment) to the wound bed, wrapped the foot with guaze, and secured it paper tape. The wound was covered with slough and surrounding skin appeasred pink/red. Staff changed gloves then cleansed the inner right knee wound with normal saline then covered it with an Allyven dressing. The surrounding skin appeared pink. Staff checked the placement of the dressing on the resident's sacrum and it was dry and intact. Throughout the procedure the resident scratched at his/her legs and attempted to kick off heel protectors. Staff replaced bilateral heel protectors

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 31	F 314		

prior to leaving the room.

Interview on 1/21/15 at 1:54 P.M. with administrative nursing staff D revealed the dietitian only reviewed residents that the facility identified as at risk.

Interview on 1/22/15 at 10:05 A.M. with administrative nursing staff D revealed he/she expected the admitting nurse to document measurements of all wounds. Staff D was unsure why the admitting nursing assessment failed to have documentation of measurements for all the resident's wounds. Staff D acknowledged he/she was unable to know for sure that the resident's heels were boggy and fluid filled upon admission of if the wounds worsened or developed since then.

Interview on 1/22/15 at 10:33 A.M. with direct care staff Q revealed staff usually offered residents other food items if they did not consume much at a meal. Staff Q reported he/she did not offer any substitutions to this resident due him/her forgetting. Staff Q also reported some days this resident ate well and other days did not.

Interview on 1/22/15 at 2:05 P.M. with licensed nursing staff I revealed the resident often removed his/her wound dressing due to scratching.

Interview on 1/22/15 at 2:55 P.M. with administrative nursing staff D revealed the resident had not been referred to the dietitian until 1/21/15.

Interview on 1/26/15 at 10:16 A.M. with direct

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 32	F 314		

care staff R revealed he/she was aware the resident had skin issues. Staff R reported the resident did receive Ensure but he/she was unsure how often. Staff R stated the staff were to document the percentage of the supplement the resident received in the as needed (prn) charting but that did not always get completed due to it being time consuming.

Interview on 1/26/15 at 11:05 A.M. with licensed nursing staff J revealed he/she expected the admitting nurse to include a skin assessment and measurements of all wounds upon admission. Staff J reported due to this resident's extensive skin impairment the dietitian should have been involved since admission. Staff J did not think staff documented supplement percentage intake. He/she reported the resident rarely finished an entire can of Ensure and usually only consumed about 50 percent. Staff J acknowledged it would be difficult to determine the resident's actual protein intake without documentation of the actual amount of the supplement that was consumed.

Interview on 1/26/15 at 11:45 A.M. with administrative nursing staff D revealed he/she was the wound nurse for the facility and knew all the resident's wounds were present at admit because the admitting nurse was present when Staff D performed the wound assessment on 1/5/15. Staff D reviewed the admitting nursing assessment with his/her first wound assessment and acknowledged the documentation did not match. Staff D reported he/she did not review the admitting nurse's skin assessment prior to completing the assessment on 1/5/15. He/she reported that he/she was attempting to educate the nursing staff regarding wound care, measuring, and assessment. Staff D stated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 33	F 314		

resident was on hospice so the family and physician decided when to refer to the dietitian. Staff D knew the dietitian saw the resident the previous week and recommended Ensure for him/her. Staff D reported the dietitian did not meet with the director of nursing or wound nurse when he/she visited. The dietitian met with the dietary manager who reported back and forth between nursing and the dietitian. The dietary manager always asked the nursing staff if any residents needed to be reviewed by the dietitian before he/she met with him/her. Staff D was unsure when the dietitian visited the facility or how often.

The interview on 1/26/15 at 12:09 P.M. with administrative nursing staff E revealed he/she acknowledged the resident's care plan lacked interventions regarding skin care for staff reference. Staff E reported the nurse that admitted this resident was new and had only a done a couple of admission prior to the resident. Staff E stated the administrative staff had noticed some of their nurses needed more guidance and leadership. He/she also acknowledged it was difficult to compare the admission nursing assessment with the subsequent assessments. Staff E reported the dietitian was involved with every admission to the facility and he/she believed the 1/21/15 visit was this resident's admission dietitian assessment. He/she said the delay between this resident's admit and the dietitian reviewing him/her was not the typical timeframe and acknowledged it was an extended amount of time. Staff E reviewed the record and reported he/she did not see any evidence the facility had attempted to contact the dietitian for a referral for this resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 34 The policy provided by the facility with a revision date of October 2010 regarding prevention or pressure ulcers revealed documentation should include the type of skin care given, date and time the care was given, the position the resident was placed, the name and title of the individual who gave care, any changes in the resident's condition, the condition of the resident's skin (i.e., the size and lcoation of any red or tender areas), how the resident tolerated the procedure, any problems or complaints made by the resident related to the procedure, if the resident refused the care and reasons why, observations of anything unusual exhibited by the resident, the signature and title of the person recording the data, and documentation of advanced directives. The facility failed to provide a policy regarding pressure ulcer care, assessment, and documentation. The facility failed to provide thorough and consistent assessment with measurements for this severely cognitively impaired resident and failed to prevent increases in size of his/her wounds and development of additional wounds.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 35	F 315		

function as possible.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 32 residents. The sample included 12 residents. Based upon observation, record review and interviews the facility failed to develop an individualized toileting program for 1 (#28) of 1 residents sampled for urinary incontinence.

Findings included:

- Resident #28's diagnoses list included the resident had a diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) without behavioral disturbances, and a traumatic brain injury (brain injury caused by sudden damage to the brain).

The resident's quarterly Minimum Data Set (MDS) 3.0 dated 12/25/14 identified the resident scored 01 (severely impaired cognition) on the Brief Interview for Mental Status, and had verbal behaviors 1 to 3 days of the 7 day assessment period. The MDS identified the resident required limited staff assistance with bed mobility, dressing, toilet use and personal hygiene, required staff supervision with transfers, was independent with walking in the room/corridor, and locomotion on/off the unit. The MDS identified the resident was frequently incontinent of urine.

The resident's Urinary Care Area Assessment dated 3/25/14 included the resident had 2 episodes of urinary incontinence during the 7 day look back period and on prior assessments the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 36	F 315		

resident was totally continent of urine.

The resident's care plan dated 1/15/15 included the resident toileted himself/herself independently or with standby assistance as needed and was continent of bowel and bladder.

The resident's Continence Evaluation dated 12/22/14 included the resident was incontinent of urine, the resident had 1 or more urinary incontinent episodes per day and the resident's urinary incontinence had worsened in the last 6 months. The resident leaked urine with physical stress, was aware of the urge to void, was able to find the toilet and was able to ask for assistance. The resident was able to remove his/her clothing to toilet and had mixed incontinence. Treatment options/interventions included prompted voiding.

The resident's clinical record lacked evidence the facility had performed a 3 day voiding diary.

On 1/21/15 at 11:15 A.M., 11:30 A.M., 11:45 A.M., 12:00 P.M., 12:10 P.M., 12:25 P.M., and at 12:40 P.M., the resident sat on a sofa in the facility. At 12:58 P.M. staff assisted the resident from the sofa to a dining table. Observation revealed staff did not toilet the resident.

On 1/12/15 the resident continued to sit at the dining room table at 12:58 P.M., 1:05 P.M., 1:10 P.M., 1:20 P.M., 1:30 P.M., 1:40 P.M., 1:50 P.M., 2:00 P.M., 2:10 P.M., and at 2:15 P.M.

On 1/21/15 at 2:30 P.M. direct care staff O assisted the resident from the dining room table and provided stand by assistance while the resident ambulated using his/her walker from the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 37	F 315		

dining room to his/her room. Direct care staff O changed the resident's jacket. The surveyor asked direct care staff O if he/she would check the resident for incontinence. Direct care staff S entered the room at that time and assisted the resident to the toilet. Observation revealed the resident was incontinent of urine and a strong urine odor was noted. Further observation revealed direct care staff S changed the resident's incontinent brief but did not provide incontinence care.

On 1/22/15 at 7:35 A.M., 7:45 A.M., 7:50 A.M., 8:00 A.M., 8:15 A.m., 8:25 A.M., 8:35 A.M., 8:45 A.M., 9:00 A.M., 9:10 A.M., 9:20 A.M., 9:30 A.M., 9:40 A.M., 9:45 A.M. the resident sat at a table in the dining room.

On 1/22/15 at 9:50 A.M. the resident ambulated independently with his/her walker out of the dining room and activity staff asked the resident to participate in the exercise group and the resident sat on a sofa. Observation did not reveal staff offered to toilet the resident.

On 1/22/15 the resident sat on the sofa at 9:50 A.M., 10:00 A.M., 10:15 A.M., 10:20 A.M., 10:28 A.M., 10:38 A.M., 10:45 A.M., 11:00 A.M., 11:12 A.M., 11:23 A.M., 11:35 A.M., 11:42 A.M. and 11:50 A.M.

On 1/22/15 at 12:00 P.M. activity staff assisted the resident from the sofa to a recliner. Observation did not reveal staff offered to toilet the resident.

On 1/22/15 at 3:05 P.M. the resident sat in a recliner. The surveyor asked direct care staff if he/she would check the resident for incontinence.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 38 Direct care staff provided stand by assistance as the resident ambulated to his/her room with his/her walker. The resident had difficulty ambulating through his/her door way and direct care staff O and direct care staff P transferred the resident to a wheelchair, propelled the resident to the common bathroom and transferred the resident to the toilet. Observation revealed the resident was incontinent of urine. Further observation staff did not provide incontinent care. Direct care staff P stated the resident was not on a scheduled toileting program. Direct care staff P stated some days the resident toileted independently if he/she was not able to ambulate without staff assistance. Direct care staff P stated staff monitored the resident's gait and if the resident was having difficulty ambulating staff assisted the resident to the toilet. On 1/26/15 at 1:56 P.M. licensed nurse H stated staff the resident was incontinent of urine and staff assisted the resident to toilet every 2 hours. He/she stated the resident's care plan should include the resident's toileting schedule. On 1/26/15 at 3:16 P.M. administrative nursing staff E stated the resident was incontinent of urine and staff assisted the resident to toilet every couple of hours. Administrative nursing staff E stated he/she was unsure if the facility had performed a 3 day voiding diary for the resident. The facility failed to develop an individualized toileting program for this severely impaired resident frequently incontinent of urine.	F 315		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 39	F 323		

as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 32 residents. The sample included 12 residents. Based upon observation, record reviews and interviews the facility failed to provide timely and effective interventions to prevent falls. The facility failed to ensure water temperatures were maintained at a safe level and also failed to ensure chemicals were not accessible to residents.

Findings included:

- Resident #28's diagnoses list included the resident had a diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) without behavioral disturbances, and a traumatic brain injury (brain injury caused by sudden damage to the brain).

The resident's quarterly Minimum Data Set (MDS) 3.0 dated 12/25/14 identified the resident scored 01 (severely impaired cognition) on the Brief Interview for Mental Status, and had verbal behaviors 1 to 3 days of the 7 day assessment period. The MDS identified the resident required limited staff assistance with bed mobility, dressing, toilet use and personal hygiene, required staff supervision with transfers, was independent with walking in the room/corridor, and locomotion on/off the unit. The MDS coded the resident was not steady but was able to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 40	F 323		

stabilize without staff assistance when walking, surface to surface transfers, and utilized a walker. The MDS identified the resident was frequently incontinent of urine, and had an ulcer (open lesion) on his/her foot.

The resident's Fall Care Area Assessment (CAA) dated 3/25/14 included the resident was at risk of falls related to receiving antidepressant, antipsychotic and antianxiety medications and also due to occasional discomfort in his/her gangrenous (death of tissue) toe.

The resident's care plan dated 1/15/14 included the resident was risk for falls/injury secondary to the use of a walker for ambulation, Alzheimer's, progressive mental deterioration characterized by confusion and memory failure), anxiety, pain, gangrene on his/her right toe, peripheral vascular disease (abnormal condition affecting the blood vessels), a history of falls, exit seeking behavior, medications and staff completed a fall risk assessment per facility protocol. Staff encouraged the resident to wear his/her glasses while walking or doing daily activities. Staff ensured the resident's call light was within reach when the resident was in his/her room unsupervised. Staff ensured the resident's bed was locked, if the resident became dizzy during position changes, staff encouraged him/her to sit for a few minutes before standing and rise slowly. Staff placed non-skid socks on the resident when in bed to assist in fall prevention. Staff observed the resident's balance and mobility, reminded the resident to request assistance when he/she changed clothing. Staff assisted the resident with seating in the dining room, and the facility educated the staff to recognize that when people performed another task while walking, such as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 41	F 323		

carrying cup of water, clothing, or supplies, he/she was more likely to fall.

A nurse's note (NN) dated 8/7/2014 and timed 2:43 P.M. documented the resident was on the floor in his/her room between the bed and recliner. The resident did not have on shoes and stated he/she was trying to get under the blankets, slipped on the floor and fell on her buttock.

According to the facility's fall investigation interventions (8/7/14 fall) included staff educated the resident about the use of non-skid shoes.

A NN dated 10/15/2014 and timed 4:45 A.M. documented the resident was found on the floor next to his/her bed. The resident's incontinent brief was around his/her lower extremities, urine was on the floor next to his/bed, on the floor in the restroom, in the trash can next to the resident's bed and the resident's pants were urine soaked. The resident did not have on non-skid shoes, the resident appeared unable to find the restroom and due to his/her confusion the resident used the trash can. Staff encouraged the resident to use his/her call light and ask for staff assistance and to put on his/her slippers when he/she got up.

According to the facility's investigation report interventions for the resident's 10/15/14 fall included staff placed a bedside commode by the resident's bed at night to decrease the resident's risk of urine leakage.

A NN dated 11/2/2014 timed 8:30 A.M. documented the resident was on the floor in the doorway of his/her room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 42	F 323		

The facility's fall investigation form for the resident's 11/2/14 included staff reminded the resident to ask for staff assistance when changing clothes.

A NN dated 11/20/2014 and timed 9:15 A.M. documented a staff heard the resident crying and observed the resident on the floor. The resident had smeared bowel movement underneath him/her, on his/her feet, legs and hands. Blood was on the floor and on the resident's face. The resident had a laceration (wound to the skin) on the top of his/her head with a large hematoma (collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma). Staff transported the resident to a local emergency department.

A NN dated 11/20/2014 and timed 11:40 A.M. documented the resident returned from the emergency department with sutures to the top of his/her head.

According to the facility's investigation report interventions for the resident's 11/20/14 fall included staff would assist the resident with toileting per the resident monitoring tool and as needed.

A NN dated 11/27/2014 timed 7:45 A.M. documented the resident was on the floor in his/her bathroom and the resident did not have on non-skid socks.

Interventions for the 11/27/2014 included staff placed non-skid shoes on the resident when the resident was in bed to assist in fall prevention.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 43	F 323		

A NN dated 12/21/2014 and timed 2:27 P.M. included the resident fell in the dining room at approximately 2:15 P.M. The resident tried to sit on a stool rather than a chair and fell onto his/her buttocks.

According to the facility's investigation report interventions for the 12/21/14 fall included staff assisted the resident when seated in the dining room.

A NN dated 1/5/2015 and timed 6:00 P.M. included the resident was in the dining room for the dinner meal and staff observed another resident attempting to assist the resident off of the floor. The resident stated he/she had a dizzy spell and sat down.

Interventions for the 1/5/15 included staff assisted the resident when rising from the chair in the dining room to ensure proper balance.

On 1/21/15 at 2:30 P.M. the resident attempted to stand from the dining room table and direct care staff O assisted the resident. The resident with much difficulty stood and ambulated with the walker and stand by assist of direct care staff O to his/her room. Observation revealed the resident had a slow gait and had a difficult time ambulating through his/her doorway and required the assistance of direct care staff O.

On 1/22/15 at 9:50 A.M. the resident independently stood up from the dining room table and ambulated out of the dining room. Observation revealed no staff assisted the resident from the table.

On 1/22/15 at 3:05 P.M. direct care staff P

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 44	F 323		

provided stand by assist while the resident ambulated to his/her room. Observation revealed as the resident entered the doorway of his/her room, the resident had a difficult time ambulating and direct care staff P assisted the resident. Observation revealed direct care P had a difficult time assisting the resident and the surveyor asked if he/she needed assistance and he/she responded yes. The surveyor summoned nursing administrative staff E and he/she asked direct care staff O to bring a wheelchair. Direct care staff O and P assisted the resident to the wheelchair.

On 1/26/14 at 8:15 A.M. the resident sat in a wheelchair at the dining room table.

On 1/26/15 at 1:56 P.M. licensed nurse stated the resident's gait was wobbly with the walker and now utilized a wheelchair. He/she stated 2 of the toes on the resident's right foot had gangrene which contributed to the resident's unsteady gait.

On 1/26/15 at 3:16 P.M. administrative nursing staff E stated toes on the resident's right foot had gangrene which was painful to the resident which contributed to the resident's unsteady gait.

The facility failed to develop timely and effective interventions for this severely cognitively impaired resident with a history of falls.

- On 1/20/15 between 8:10 AM and 9:00 AM the housekeeping closet was unlocked and unattended, the closet contained:
3 one gallon containers of Doubilet Carpet Cleaner with a label that read keep out of reach of children, hazardous to humans, corrosive causes irreversible eye damage and skin burns.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 45	F 323		

One half of a container of (32 ounces) of Meyer Strike out heavy duty all-purpose foaming cleaner and degreaser with a warning label that read keep out of reach of children, skin and eye irritant.

One gallon (approximately half full and uncapped) container of LD64-multigermicidal detergent and deodorant with a label that read keep out of reach of children.

On 1/20/15 at 9:00 AM housekeeping staff X confirmed the door should be locked.

Although requested the facility failed to provide a policy on chemical storage.

The facility failed to ensure the residents remained free of hazards when staff failed to store chemicals in secure areas.

- On 1/20/15 between 8:10 AM and 9:00 AM during initial tour the soiled utility room sink had a water temperature of 123.4 degrees Fahrenheit (F). The physical therapy room sink on the same hall had a water temperature of 122 degrees F. The activity room sink had a water temperature of 120.3.

On 1/20/15 at 9:00 AM the temperatures were taken by another surveyor using a different thermometer. The soiled utility sink had a temperature of 127.7 degrees F, the physical therapy room sink had a temperature of 120.2 degrees F and the activity room sink water was 125.7 degrees F.

On 1/21/15 at 10:30 AM a tour with maintenance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 46 staff Y obtained the following temperatures the soiled utility sink water thermometer read 123.4, the physical therapy room water temperature was 114.1, and the activity room water temperature was 112.6 using his/her thermometer. On 1/21/15 at 10:30 AM maintenance staff Y revealed the water temperatures varied due to being on the same line as the dining room and laundry. He/she revealed that temperatures may be higher in the morning if laundry and dining room are not fully running. On 1/22/15 at 7:44 AM maintenance staff Y revealed he/she had " tweaked " the mixing valve and the temperatures were a bit lower, the physical therapy sink water temperature was 123.5, the beauty shop water temperature was 122 degrees F, the bath down the hall from the beauty shop water temperature was 120.8 degrees F, the activity room sink water temperature was 118/4 and the soiled utility room water temperature was 122.9 degrees F. Review of the facilities weekly water temperature log for November and December 2014 and January 2015 showed no temperatures over 120 degrees F but the temperatures were only obtained in the shower rooms on the 3 facility hallways. Although requested the facility failed to provide a policy on hot water temperatures. The facility failed to ensure the residents remained free of accidents and hazards when water temperatures were above 120 degrees F.	F 323		
F 325	483.25(i) MAINTAIN NUTRITION STATUS	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325 SS=G	Continued From page 47 UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: The facility identified a census of 32 residents. The sample included 12 residents. Based on observation, record review, and interview the facility failed to provide timely nutritional interventions for 1 (#7) for 4 residents reviewed for nutrition, who experienced significant weight loss of 16.6 percent and had multiple wounds. Findings included: - The admission Minimum Data Set (MDS) dated 1/8/15 for resident #7 revealed a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. He/she required extensive assistance from 2 or more staff for bed mobility, dressing, toilet use, and personal hygiene. The resident was dependent on staff for transferring and bathing. His/her weight was 140 pounds (#), he/she received a mechanically altered diet, and required supervision with 1 staff physical assist for eating. He/she had a prognosis of 6 months or less and had 5 stage 1 pressure	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 48	F 325		

ulcers, 1 stage 2 pressure ulcer, 1 stage 3 pressure ulcer, 1 stage 4 pressure ulcer, and 4 unstageable pressure ulcers.

The 1/9/15 Care Area Assessment (CAA) regarding nutrition revealed the resident had extensive skin issues and staff were going to refer him/her to the dietitian to determine if hydration and/or supplements could improve his/her skin condition.

The interim care plan dated 12/29/14 failed to address nutritional needs.

The comprehensive care plan with a revision date of 1/15/15 revealed the resident had actual impairment to skin integrity related to inadequate dietary intake and limited physical mobility. The care plan also revealed he/she was at risk for a nutritional problem due to a terminal diagnosis. The resident required assistance from staff to eat, requiring verbal cueing throughout meals. Staff invited the resident to activities that promoted additional intake, monitored and reported signs and symptoms of trouble swallowing, served his/her diet as ordered, and weighed the resident weekly at the same time. The care plan showed staff provided and served supplements as ordered and the form indicated for the person completing it to specify what type of supplement, but the care plan lacked that information.

Review of the clinical record revealed the following weights:
- 12/29/14 equaled (=) 147.7#
- 1/8/15 = 140.0#, The clinical record lacked evidence the facility contacted the dietitian or physician or implemented any interventions to prevent further weight loss.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 49	F 325		

- 1/20/15 = 122.2# (a 12.7 percent (%) loss since 1/8/15)
- 1/25/15 = 116.8# (a 16.6% loss since 1/8/15),
The facility received a dietitian recommendation on 1/21/15 to start Ensure twice daily but the clinical record lacked evidence staff initiated the Ensure.

The 12/31/14 laboratory results revealed an albumin level (blood test used to measure the amount of protein in the blood, used in part to determine a person's nutritional status) was low at 3.2 and the desirable range was 3.5 to (-) 5.2. His/her total protein level was low at 6.2 and the desirable range was 6.6 - 8.7.

Review of the clinical record on 1/21/15 at 1:59 P.M. lacked evidence the dietitian assessed the resident as indicated by the nutrition CAA.

The 1/21/15 at 4:04 P.M. faxed physician notification provided by the facility revealed the staff notified the physician the resident was being weighed by the hoyer lift (mechanical lift). When the resident was first weighed with the hoyer he/she weighed 140# and more current weight of 122.2#. Staff did not believe the scale had been zeroed out prior to weighing the resident for the 122.2# result. Staff asked the physician if they could monitor for the next weeks weight to compare. The physician replied 1/21/15 at 4:10 PM and approved the request to monitor and reweigh the following week.

The 1/21/15 at 5:43 P.M. nutrition progress note revealed the dietitian reviewed the resident (23 days after admission). The note showed the resident weighed 122.2# and his/her previous weight was 140#, noting a 17# weight loss

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 50	F 325		

recently. The note showed he/she had decreased intake and appetite with weakness and a recent fall. The resident's diet was regular with mechanical soft texture and staff encouraged fluids. The note also revealed the resident's skin was intact, told the reader to refer to nursing, and showed the resident had a fracture of the hip previously noted in the medical record. Medications were reviewed and he/she may benefit from supplement for increased nutrition needs. The dietitian recommended Ensure Plus twice a day at med pass. Staff were to continue with the plan of care, check weights weekly, and monitor as needed.

Review of the January 2015 Medication and Treatment Administration Record (MAR/TAR) on 1/26/15 at 7:17 A.M. lacked documentation showing staff provided the resident with Ensure Plus twice a day since the dietitian recommended per the 1/21/14 at 5:43 P.M. note.

Observation on 1/22/15 at 8:25 A.M. revealed the resident sat in a broda chair at a table in the dining room and received eggs, biscuits and gravy, oatmeal, grape juice, milk, and water. The resident was able to eat and drink with intermittent cueing from staff. At 8:45 A.M. the staff left the table and the resident sat quietly. He/she consumed approximately 5-10% of the meal. At 9:10 A.M. 3 staff members returned to table but did not engage in conversation with the resident. The resident sat in his/her broda chair quietly with his/her eyes closed until 9:26 A.M. when direct care staff Q propelled the resident from the dining room to his/her room, locked the brakes, placed the call light in reach, and exited the room. Staff failed to encourage the resident during the meal and failed to offer him/her an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 51	F 325		

alternate.

Interview on 1/21/15 at 1:54 P.M. with administrative nursing staff D revealed the dietitian only reviewed residents that the facility identified as at risk.

Interview on 1/22/15 at 10:33 A.M. with direct care staff Q revealed staff usually offered residents other food items if they did not consume much at a meal. Staff Q reported he/she did not offer any substitutions to this resident due him/her forgetting. Staff Q also reported some days this resident ate well and other days did not.

Interview on 1/22/15 at 2:55 P.M. with administrative nursing staff D revealed the resident was not referred to the dietitian until 1/21/15.

Interview on 1/22/15 at 3:53 P.M. with direct care staff P revealed the resident had multiple pressure wounds. Staff P also reported the resident's need for assistance with eating fluctuated and that staff offered him/her snacks when he/she did not eat well at a meal.

Interview on 1/26/15 at 10:16 A.M. with direct care staff R revealed he/she was aware the resident had skin issues. Staff R reported the resident did receive Ensure but he/she was unsure how often. Staff R stated the staff were to document the percentage of the supplement the resident received in the as needed (prn) charting but that did not always get completed due to it being time consuming.

Interview on 1/26/15 at 11:05 A.M. with licensed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 52	F 325		

nursing staff J revealed due to this resident's extensive skin impairment the dietitian should have been involved since admission. Staff J did not think staff documented supplement percentage intake. He/she reported the resident rarely finished an entire can of Ensure and usually only consumed about 50 percent. Staff J acknowledged it would be difficult to determine the resident's actual protein intake without documentation of the actual amount of the supplement that the resident consumed.

Interview on 1/26/15 at 11:45 A.M. with administrative nursing staff D revealed the resident was on hospice so the family and physician decided when to refer to the dietitian. Staff D knew the dietitian saw the resident the previous week and recommended Ensure for him/her. Staff D reported the dietitian did not meet with the director of nursing or wound nurse when he/she visited. The dietitian met with the dietary manager who reported back and forth between nursing and the dietitian. The dietary manager always asked the nursing staff if any residents needed to be reviewed by the dietitian before he/she met with him/her. Staff D was unsure when the dietitian visited the facility or how often.

The interview on 1/26/15 at 12:09 P.M. with administrative nursing staff E revealed the dietitian was involved with every admission to the facility and he/she believed the 1/21/15 visit was this resident's admission dietitian assessment. He/she said the delay between this resident's admit and the dietitian reviewing him/her was not the typical timeframe and acknowledged it was an extended amount of time. Staff E reviewed the record and reported he/she did not see any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 53 evidence the facility attempted to contact the dietitian for a referral for this resident. The facility failed to provide a policy regarding monitoring nutritional status. The facility failed to develop and implement timely interventions to prevent significant weight loss for this severely cognitively impaired resident with 12 known pressure ulcers.	F 325		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 54	F 329		

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 32 residents with 5 residents reviewed for unnecessary medications. Based on observation, interview and record review the facility failed to ensure 5 of the 5 residents did not receive unnecessary medications (medications used without adequate monitoring), when staff failed to identify Black Box Warnings (BBW) and side effects for prescribed medications. (23, 29, 52, 33 and 28)

Findings included:

- Resident #23 ' s 10/30/14 Quarterly Minimum Data Set (MDS) revealed the resident had severely impaired cognition, physical and verbal behaviors directed toward others during the 7 day look back period. The resident required extensive assistance of 2 staff with Activities of Daily Living (ADL ' s). The resident received 7 days of antipsychotic, antianxiety, antidepressant and diuretics during the review period.

The resident ' s Cognitive loss/dementia Care Area Assessment (CAA) dated 4/29/14 revealed the resident had a history of dementia (progressive mental disorder characterized by failing memory, confusion) and anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). The resident received Namenda (an Alzheimer ' s medication), Zyprexa (an antipsychotic) and as needed (PRN) and Ativan (an antianxiety).

The Psychotropic Medication CAA dated 4/29/14 revealed the resident had a history of dementia and anxiety, both with behaviors.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

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F 329	Continued From page 55	F 329		

The residents revised 11/19/14 care plan instructed staff that the resident required assistance with ADL ' s. The care plan lacked information related to potential side effects and adverse reactions for the use of Busparione (an antianxiety) 5 milligram (mg) twice a day (BID), Cymbalta 30 mg (an antidepressant), Depakote (a mood stabilizer) 250 mg BID, and Zyprexa (an antipsychotic) 5 mg all with Black Box Warnings.

According to www.fda.gov, bupropion had a black box warning for patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior.

According to www.fda.gov, Cymbalta had a black box warning of monitor for worsening and emergence of suicidal thoughts and behaviors.

According to www.fda.gov, Depakote had a black box warning of life threatening adverse reactions. Hepatotoxicity (toxic liver disease), including death, usually during the first 6 months of treatment. Monitor patients closely, and perform liver function tests prior to therapy and at frequent intervals thereafter, also included risk of pancreatitis (inflammation of the pancreas, a large gland of the body near the stomach and that produces insulin and other substances that help the body digest food) including hemorrhagic (loss of a large amount of blood in a short period of time) cases.

According to www.fda.gov, Zyprexa had a black box warning of: increased mortality in elderly patients with dementia-related psychosis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 56	F 329		

On 01/21/2015 at 11:15 AM the resident sat in his/her room in rocking chair, no signs or symptoms of pain, eyes closed.
On 1/21/15 at 2:12 PM the resident sat in his/her room and visited with a friend. The resident did not exhibit any signs of behaviors or discomfort.

On 01/22/2015 at 2:13 PM, direct care staff P revealed the resident had threatening behaviors as well as rejection of care at times. He/she revealed that the direct care staff chart the resident ' s behaviors in the Kiosk (computer used for charting resident information by staff) and report the behaviors to the charge nurse. Staff P was unaware of information on the care plan for BBW.

On 1/22/15 at 2:05 PM, licensed staff H revealed that the list of BBW for resident #23 were noted on the Medication Administration Record (MAR) and there was a book on the medication cart that had the BBW ' s listed.

On 1/26/15 at 3:53 PM, Administrative Nurse E confirmed that BBW were not on the residents care plan.

The facility failed to ensure that resident #23 did not receive unnecessary medications when they failed to adequately monitor for potential side effects related to Black Box Warnings.

- Resident #29 ' s 10/23/14 Quarterly Minimum Data Set (MDS) revealed the resident had severely impaired cognition, inattention and disorganized thinking that fluctuated. The resident also had physical and verbal behaviors towards others and wandered. The resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 57	F 329		

required extensive assistance of two staff with activities of daily living (ADL ' s). The resident received 7 days of antipsychotic, antianxiety and antidepressant and 3 days of antibiotics during the 7 day look back period.

The resident ' s 1/20/14 Cognitive loss/dementia and psychotropic medication Care Area Assessment (CAA) were not filled out.

The residents revised nursing care plan dated 11/14/14 informed staff that the resident had an altered mental status evidenced by confusion, impaired memory, history of verbalizing suicidal ideation related to depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), Alzheimer ' s dementia (progressive mental deterioration characterized by confusion and memory failure) with behavioral disturbance. The plan instructed staff to administer psychotropic medications as ordered, monitor for efficacy and complete the AIMS (abnormal involuntary movement assessment) quarterly and report any changes to the resident ' s physician. The plan also instructed staff that the resident had the potential to be physically aggressive related to dementia and that staff should anticipate the resident ' s needs: food, thirst, toileting needs, comfort level, body positioning, and pain and provide physical and verbal cues to alleviate anxiety. The care plan lacked information related to potential side effects and adverse reactions for the use of Depakote Sprinkles (a mood stabilizer) 125mg twice a day (BID), Trazadone (an antidepressant) 50mg and Zyprexa (an antipsychotic) 2.5mg, Metoprolol (an antihypertensive) 50mg.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 58	F 329		

According to www.fda.gov, Depakote had a black box warning of life threatening adverse reactions. Hepatotoxicity (toxic liver disease), including death, usually during the first 6 months of treatment. Monitor patients closely, and perform liver function tests prior to therapy and at frequent intervals thereafter. Also included risk of pancreatitis (inflammation of the pancreas, a large gland of the body near the stomach and that produces insulin and other substances that help the body digest food) including hemorrhagic (loss of a large amount of blood in a short period of time) cases.
According to www.fda.gov, Trazodone had a black box warning of patients who are started on therapy should be observed closely for clinical worsening, suicidality, or unusual changes in behavior

According to www.fda.gov, Zyprexa had a black box warning of: increased mortality in elderly patients with dementia-related psychosis.

According to www.fda.gov, Toprol had a black box warning of ischemic heart disease (reduced blood supply to the heart).

On 01/21/2015 at 3:33 PM, the resident sat and visited with friends and spouse, no signs of verbal or physical behavior.

On 1/22/15 at 2:13 PM, direct care staff P revealed the resident did have behaviors at times. He/she refused cares and wandered through the facility. Staff P revealed that the direct care staff chart the resident ' s behaviors in the Kiosk (computer used for charting resident information by staff) and report the behaviors to the charge nurse. Staff P was unaware of information on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 59	F 329		

care plan for BBW.

On 1/22/15 at 2:55 PM, licensed staff H revealed that the list of BBW for resident #23 were noted on the Medication Administration Record (MAR) and there was a book on the medication cart that had the BBW ' s listed.

On 1/26/15 at 3:53 PM, Administrative Nurse E confirmed that BBW were not on the residents care plan.

The facility failed to ensure that resident #29 did not receive unnecessary medications when they failed to adequately monitor for potential side effects related to Black Box Warnings.

- Resident #52 ' s 12/29/14 Admission Minimum Data Set (MDS) revealed the resident had moderately impaired cognition, disorganized thinking and delusions. The resident required extensive assistance from staff for activities of daily living (ADL ' s). He/she received 7 days of insulin injections and antidepressants.

The residents 12/29/14 psychotropic medication use Care Area Assessment (CAA) revealed the resident verbalized feelings of depression, received scheduled Trazadone (an antidepressant) at bedtime.

The resident ' s revised nursing care plan dated 1/13/15 instructed staff that the resident had behavior problems and had a potential to be physically aggressive, makes sexually inappropriate comments to staff related to dementia (progressive mental disorder characterized by failing memory, confusion). The care plan instructed staff to administer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 60	F 329		

medications as ordered, monitor and document for side effects and effectiveness. The plan instructed staff to encourage the resident to express his/her feelings appropriately and approach in a calm manner. The plan instructed staff that the resident had impaired cognitive function with dementia and to administer his/her medications as ordered. The care plan lacked information related to adverse reactions for the use of Buspirone (an antianxiety) 10 milligram (mg) ½ tab, Trazadone (an antidepressant) 100mg and Cymbalta (an antidepressant) 90 mg all with black box warnings.

According to www.fda.gov, buspirone had a black box warning of patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior.

According to www.fda.gov, Trazodone had a black box warning of patients who are started on therapy should be observed closely for clinical worsening, suicidality, or unusual changes in behavior.

According to www.fda.gov, Cymbalta had a black box warning of monitor for worsening and emergence of suicidal thoughts and behaviors.

On 1/22/15 at 12:33 PM, the resident propelled self in wheelchair toward the dining room. The resident visited with staff and other residents, no behaviors noted at this time.

On 1/22/15 at 2:13 PM, direct care staff P revealed that the resident had behaviors such as anger and making sexual innuendos towards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 61	F 329		

staff. He/she revealed that the direct care staff chart the resident ' s behaviors in the Kiosk (computer used for charting resident information by staff) and report the behaviors to the charge nurse. Staff P was unaware of information on the care plan for BBW.

On 1/22/15 at 2:05 PM, licensed staff H revealed that the list of BBW for resident #23 were noted on the Medication Administration Record (MAR) and there was a book on the medication cart that had the BBW ' s listed.

On 1/26/15 at 3:53 PM, Administrative Nurse E confirmed that BBW were not on the residents care plan.

The facility failed to ensure that resident #52 did not receive unnecessary medications when they failed to adequately monitor for potential side effects related to Black Box Warnings.

- Resident #33 ' s Admission Minimum Data Set (MDS) dated 10/28/14 revealed the resident had intact cognition, minimal depression and no behaviors. The resident required minimal assistance from one staff for his/her activities of daily living (ADL ' s). The resident received 7 days of antianxiety, antidepressant and hypnotic medications during the look back period.

The 10/28/14 Psychotropic medication Care Area Assessment (CAA) revealed the resident needed to be monitored for mood and behavior and to remain free from complications of his/her medications.

The revised nursing care plan dated 11/14/14 revealed the resident was independent for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 62	F 329		

meeting emotional, intellectual, physical and social needs. The care plan lacked information related to potential side effects and adverse reactions for the use of Coumadin (an anticoagulant) 2milligram (mg), Trazadone (an antidepressant) 50mg, Toprol (an antihypertensive) 100mg, and Acetaminophen (pain reliever) 500mg every 4 hours as needed, Hydrocodone/ Acetaminophen 5-325 mg (an narcotic pain reliever) all with black box warnings.

According to www.fda.gov, Coumadin had a black box warning of bleeding risk. Coumadin could cause major or fatal bleeding.

According to www.fda.gov, Trazodone had a black box warning of patients who are started on therapy should be observed closely for clinical worsening, suicidality, or unusual changes in behavior.

According to www.fda.gov, Toprol had a black box warning of ischemic heart disease (reduced blood supply to the heart).

According to www.fda.gov Acetaminophen had a black box warning of liver injury if taken in excess.

On 1/21/15 at 11:56 AM, the resident sat in a wheelchair in the dining room and talked with other residents.

On 1/22/15 at 3:53 PM direct care staff P revealed the resident had minimal behaviors, liked to remain in his/her room. Staff P stated if the resident had a behavior it is charted in the Kiosk and the information is relayed to the charge

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 63	F 329		

nurse.

On 1/26/15 at 10:40 AM, licensed staff H revealed that the list of BBW ' s are kept in a book on the medication cart and that the Medication Administration Record showed which of the medications had black box warnings.

On 1/26/15 at 12:09 PM, administrative nurse E confirmed that black box warnings were not included in the residents care plan.

The facility failed to ensure that resident #33 did not receive unnecessary medications when they failed to adequately monitor for potential side effects related to Black Box Warnings.

- Resident #28 ' s Quarterly Minimum Data Set (MDS) dated 12/25/14 revealed the resident had severely impaired cognition and verbal behaviors during the 7 day look back period. The resident required minimal assistance from staff with his/her activities of daily living (ADLs). The resident received antianxiety, antipsychotic and antipsychotic medications 7 of the 7 days in the assessment period.

The resident ' s Behavior Care Area Assessment (CAA) dated 3/25/14 revealed the resident's behaviors had become a very large problem but had seen some improvements since re-entry.

The residents revised care plan dated 1/15/15 instructed staff to monitor for signs and symptoms of depression, infection and pain. The care plan lacked information related to potential side effects and adverse reactions for the use of Trazadone (an antidepressant), Zoloft (an antidepressant), Zyprexa (an antipsychotic)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 64	F 329		

Depakote (a mood stabilizer) all with Black Bow Warnings.

According to www.fda.gov, Trazodone had a black box warning of patients who are started on therapy should be observed closely for clinical worsening, suicidality, or unusual changes in behavior.

According to www.fda.gov , Zoloft had a black box warning of patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior.

According to www.fda.gov, Zyprexa had a black box warning of: increased mortality in elderly patients with dementia-related psychosis.

According to www.fda.gov Depakote had a black box warning of life threatening adverse reactions. Hepatotoxicity (toxic liver disease), including death, usually during the first 6 months of treatment. Monitor patients closely, and perform liver function tests prior to therapy and at frequent intervals thereafter. Also included risk of pancreatitis (inflammation of the pancreas, a large gland of the body near the stomach and that produces insulin and other substances that help the body digest food) including hemorrhagic (loss of a large amount of blood in a short period of time) cases.

On 1/21/15 at 11:15 A.M. the resident sat on the sofa in the main lobby area.

On 01/22/2015 at 1:30 PM, direct care staff P revealed the resident had threatening behaviors

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 65 as well as rejection of care at times. He/she revealed that the direct care staff chart the resident ' s behaviors in the Kiosk (computer used for charting resident information by staff) and report the behaviors to the charge nurse. Staff P was unaware of information on the care plan for BBW. On 1/22/15 at 1:30 PM, licensed staff H revealed that the list of BBW for resident #23 were noted on the Medication Administration Record (MAR) and there was a book on the medication cart that had the BBW ' s listed. On 1/26/15 at 3:53 PM, Administrative Nurse E confirmed that BBW were not on the residents care plan. The facility failed to ensure that resident #28 did not receive unnecessary medications when they failed to adequately monitor for potential side effects related to Black Box Warnings.	F 329		
F 354 SS=E	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.	F 354		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 354	Continued From page 66 This REQUIREMENT is not met as evidenced by: The facility reported a census of 32 residents. Based on interview and record review the facility failed to provide 8 hour Registered Nurse (RN) coverage to meet the resident ' s needs for nursing care in a manner that promotes each resident ' s physical, mental and psychosocial well-being, enhancing their quality of life. Findings include: - Review of the facilities schedule from August 24 2014- January 26 2015 the facility lacked RN coverage on the following dates: August 2014- 24, 30 and 31 September 2014- 6, 7,13,14,20, 21, 27, 28 October 2014- 4, 5, 11, 12,18,19,26 November 2014- 2, 9, 15, 30 the schedule from 11/16-11/29/14 was not provided December 2014- 14 January 2015- 25 On 1/26/15 at 3:00 PM administrative nursing staff E revealed that the RN on duty at the hospital provides the RN coverage when there is not one on staff on the long term care side and the hospital does not have patients. Staff E stated he/she was on call for the facility 24 hours a day. The facility failed to provide 8 hours of RN coverage to meet the resident ' s needs.	F 354		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 67	F 428		

The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 32 residents with 5 residents reviewed for unnecessary medications. Based on observation, interview and record review the facility failed to ensure the consultant pharmacist identified and reported any irregularities to the director of nursing and physician related to Black Box Warnings (BBW) and side effects for prescribed medications. (23, 29, 52, 33 and 28)

Findings included:

- Resident #23 ' s 10/30/14 Quarterly Minimum Data Set (MDS) revealed the resident had severely impaired cognition, physical and verbal behaviors directed toward others during the 7 day look back period. The resident required extensive assistance of 2 staff with Activities of Daily Living (ADL ' s). The resident received 7 days of antipsychotic, antianxiety, antidepressant and diuretics during the review period.

The resident ' s Cognitive loss/dementia Care Area Assessment (CAA) dated 4/29/14 revealed the resident had a history of dementia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 68	F 428		

(progressive mental disorder characterized by failing memory, confusion) and anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). The resident received Namenda (an Alzheimer ' s medication), Zyprexa (an antipsychotic) and as needed (PRN) and Ativan (an antianxiety).

The Psychotropic Medication CAA dated 4/29/14 revealed the resident had a history of dementia and anxiety, both with behaviors.

The residents revised 11/19/14 care plan instructed staff that the resident required assistance with ADL ' s. The care plan lacked information related to potential side effects and adverse reactions for the use of Busparione (an antianxiety) 5 milligram (mg) twice a day (BID), Cymbalta 30 mg (an antidepressant), Depakote (a mood stabilizer) 250 mg BID, and Zyprexa (an antipsychotic) 5 mg all with Black Box Warnings.

According to www.fda.gov, bupropion had a black box warning for patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior.

According to www.fda.gov, Cymbalta had a black box warning of monitor for worsening and emergence of suicidal thoughts and behaviors.

According to www.fda.gov, Depakote had a black box warning of life threatening adverse reactions. Hepatotoxicity (toxic liver disease), including death, usually during the first 6 months of treatment. Monitor patients closely, and perform liver function tests prior to therapy and at frequent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 69	F 428		

intervals thereafter, also included risk of pancreatitis (inflammation of the pancreas, a large gland of the body near the stomach and that produces insulin and other substances that help the body digest food) including hemorrhagic (loss of a large amount of blood in a short period of time) cases.

According to www.fda.gov, Zyprexa had a black box warning of: increased mortality in elderly patients with dementia-related psychosis.

The resident ' s monthly drug regimen reviews dated 5/13/14 -1/21/15 lacked evidence the consultant pharmacist acknowledged the lack of Black Box Warnings and side effects on the residents care plan.

On 01/21/2015 at 11:15 AM the resident sat in his/her room in rocking chair, no signs or symptoms of pain, eyes closed.

On 1/21/15 at 2:12 PM the resident sat in his/her room and visited with a friend. The resident did not exhibit any signs of behaviors or discomfort.

On 1/27/15 at 1:33 PM, Consultant Pharmacist KK reported he/she did not look at the facilities care plans or medication administration record for Black Box Warnings.

The facility failed to ensure the consultant pharmacist identified irregularities related to adequately monitoring for potential side effects related to Black Box Warnings.

- Resident #29 ' s 10/23/14 Quarterly Minimum Data Set (MDS) revealed the resident had severely impaired cognition, inattention and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 70	F 428		

disorganized thinking that fluctuated. The resident also had physical and verbal behaviors towards others and wandered. The resident required extensive assistance of two staff with activities of daily living (ADL ' s). The resident received 7 days of antipsychotic, antianxiety and antidepressant and 3 days of antibiotics during the 7 day look back period.

The resident ' s 1/20/14 Cognitive loss/dementia and psychotropic medication Care Area Assessment (CAA) were not filled out.

The residents revised nursing care plan dated 11/14/14 informed staff that the resident had an altered mental status evidenced by confusion, impaired memory, history of verbalizing suicidal ideation related to depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), Alzheimer ' s dementia (progressive mental deterioration characterized by confusion and memory failure) with behavioral disturbance. The plan instructed staff to administer psychotropic medications as ordered, monitor for efficacy and complete the AIMS (abnormal involuntary movement assessment) quarterly and report any changes to the resident ' s physician. The plan also instructed staff that the resident had the potential to be physically aggressive related to dementia and that staff should anticipate the resident ' s needs: food, thirst, toileting needs, comfort level, body positioning, and pain and provide physical and verbal cues to alleviate anxiety. The care plan lacked information related to potential side effects and adverse reactions for the use of Depakote Sprinkles (a mood stabilizer) 125mg twice a day (BID), Trazadone (an antidepressant) 50mg and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 71	F 428		

Zyprexa (an antipsychotic) 2.5mg, Metoprolol (an antihypertensive) 50mg.

According to www.fda.gov, Depakote had a black box warning of life threatening adverse reactions. Hepatotoxicity (toxic liver disease), including death, usually during the first 6 months of treatment. Monitor patients closely, and perform liver function tests prior to therapy and at frequent intervals thereafter. Also included risk of pancreatitis (inflammation of the pancreas, a large gland of the body near the stomach and that produces insulin and other substances that help the body digest food) including hemorrhagic (loss of a large amount of blood in a short period of time) cases.
According to www.fda.gov, Trazodone had a black box warning of patients who are started on therapy should be observed closely for clinical worsening, suicidality, or unusual changes in behavior

According to www.fda.gov, Zyprexa had a black box warning of: increased mortality in elderly patients with dementia-related psychosis.

According to www.fda.gov, Toprol had a black box warning of ischemic heart disease (reduced blood supply to the heart).

The residents monthly drug regimen review from 1/4/14-1/15/ lacked evidence the consultant pharmacist acknowledged the lack of Black Box Warnings and side effects on the residents care plan.

On 01/21/2015 at 3:33 PM, the resident sat and visited with friends and spouse, no signs of verbal or physical behavior.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 72	F 428		

On 1/27/15 at 1:33 PM, Consultant Pharmacist KK reported he/she did not look at the facilities care plans or medication administration record for Black Box Warnings.

The facility failed to ensure the consultant pharmacist identified irregularities related to adequately monitoring for potential side effects related to Black Box Warnings.

- Resident #52 ' s 12/29/14 Admission Minimum Data Set (MDS) revealed the resident had moderately impaired cognition, disorganized thinking and delusions. The resident required extensive assistance from staff for activities of daily living (ADL ' s). He/she received 7 days of insulin injections and antidepressants.

The residents 12/29/14 psychotropic medication use Care Area Assessment (CAA) revealed the resident verbalized feelings of depression, received scheduled Trazadone (an antidepressant) at bedtime.

The resident ' s revised nursing care plan dated 1/13/15 instructed staff that the resident had behavior problems and had a potential to be physically aggressive, makes sexually inappropriate comments to staff related to dementia (progressive mental disorder characterized by failing memory, confusion). The care plan instructed staff to administer medications as ordered, monitor and document for side effects and effectiveness. The plan instructed staff to encourage the resident to express his/her feelings appropriately and approach in a calm manner. The plan instructed staff that the resident had impaired cognitive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 73	F 428		

function with dementia and to administer his/her medications as ordered. The care plan lacked information related to adverse reactions for the use of Buspirone (an antianxiety) 10 milligram (mg) ½ tab, Trazadone (an antidepressant) 100mg and Cymbalta (an antidepressant) 90 mg all with black box warnings.

According to www.fda.gov, buspirone had a black box warning of patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior.

According to www.fda.gov, Trazodone had a black box warning of patients who are started on therapy should be observed closely for clinical worsening, suicidality, or unusual changes in behavior.

According to www.fda.gov, Cymbalta had a black box warning of monitor for worsening and emergence of suicidal thoughts and behaviors.

The residents admitting drug regiemen review dated 1/15/15 lacked evidence the consultant pharmacist acknowledged the lack of Black Box Warnings and side effects on the residents care plan.

On 1/22/15 at 12:33 PM, the resident propelled self in wheelchair toward the dining room. The resident visited with staff and other residents, no behaviors noted at this time.

On 1/27/15 at 1:33 PM, Consultant Pharmacist KK reported he/she did not look at the facilities care plans or medication administration record for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 74 Black Box Warnings The facility failed to ensure the consultant pharmacist identified irregularities related to adequately monitoring for potential side effects related to Black Box Warnings. - Resident #33' s Admission Minimum Data Set (MDS) dated 10/28/14 revealed the resident had intact cognition, minimal depression and no behaviors. The resident required minimal assistance from one staff for his/her activities of daily living (ADL ' s). The resident received 7 days of antianxiety, antidepressant and hypnotic medications during the look back period. The 10/28/14 Psychotropic medication Care Area Assessment (CAA) revealed the resident needed to be monitored for mood and behavior and to remain free from complications of his/her medications. The revised nursing care plan dated 11/14/14 revealed the resident was independent for meeting emotional, intellectual, physical and social needs. The care plan lacked information related to potential side effects and adverse reactions for the use of Coumadin (an anticoagulant) 2milligram (mg), Trazadone (an antidepressant) 50mg, Toprol (an antihypertensive) 100mg, and Acetaminophen (pain reliever) 500mg every 4 hours as needed, Hydrocodone/ Acetaminophen 5-325 mg (an narcotic pain reliever) all with black box warnings. According to www.fda.gov, Coumadin had a black box warning of bleeding risk. Coumadin could cause major or fatal bleeding.	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 75	F 428		

According to www.fda.gov, Trazodone had a black box warning of patients who are started on therapy should be observed closely for clinical worsening, suicidality, or unusual changes in behavior.

According to www.fda.gov, Toprol had a black box warning of ischemic heart disease (reduced blood supply to the heart).

According to www.fda.gov Acetaminophen had a black box warning of liver injury if taken in excess.

The resident ' s monthly drug regimen review dated 11/10/14 - 1/15/15 lacked evidence the consultant pharmacist acknowledged the lack of Black Box Warnings and side effects on the residents care plan.

On 1/21/15 at 11:56 AM, the resident sat in a wheelchair in the dining room and talked with other residents.

On 1/27/15 at 1:33 PM, Consultant Pharmacist KK reported he/she did not look at the facilities care plans or medication administration record for Black Box Warnings.

The facility failed to ensure the consultant pharmacist identified irregularities related to adequately monitoring for potential side effects related to Black Box Warnings.

- Resident #28 ' s Quarterly Minimum Data Set (MDS) dated 12/25/14 revealed the resident had severely impaired cognition and verbal behaviors during the 7 day look back period. The resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 76	F 428		

required minimal assistance from staff with his/her activities of daily living (ADLs). The resident received antianxiety, antipsychotic and antipsychotic medications 7 of the 7 days in the assessment period.

The resident ' s Behavior Care Area Assessment (CAA) dated 3/25/14 revealed the resident ' s behaviors had become a very large problem but had seen some improvements since re-entry.

The residents revised care plan dated 1/15/15 instructed staff to monitor for signs and symptoms of depression, infection and pain. The care plan lacked information related to potential side effects and adverse reactions for the use of Trazadone (an antidepressant), Zoloft (an antidepressant), Zyprexa (an antipsychotic) Depakote (a mood stabilizer) all with Black Bow Warnings.

According to www.fda.gov, Trazodone had a black box warning of patients who are started on therapy should be observed closely for clinical worsening, suicidality, or unusual changes in behavior.

According to www.fda.gov , Zoloft had a black box warning of patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior.

According to www.fda.gov Zyprexa had a black box warning of: increased mortality in elderly patients with dementia-related psychosis.

According to www.fda.gov Depakote had a black

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 77 box warning of life threatening adverse reactions. Hepatotoxicity (toxic liver disease), including death, usually during the first 6 months of treatment. Monitor patients closely, and perform liver function tests prior to therapy and at frequent intervals thereafter. Also included risk of pancreatitis (inflammation of the pancreas, a large gland of the body near the stomach and that produces insulin and other substances that help the body digest food) including hemorrhagic (loss of a large amount of blood in a short period of time) cases. The resident ' s monthly drug regimen reviews dated lacked evidence the consultant pharmacist acknowledged the lack of Black Box Warnings and side effects on the residents care plan. On 1/21/15 at 11:15 A.M. the resident sat on the sofa in the main lobby area. On 1/27/15 at 1:33 PM, Consultant Pharmacist KK reported he/she did not look at the facilities care plans or medication administration record for Black Box Warnings. The facility failed to ensure the consultant pharmacist identified irregularities related to adequately monitoring for potential side effects related to Black Box Warnings.	F 428		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 78 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: The facility reported a census of 32 residents with three hallways on the main unit. Based on observation, interview and record review, the facility failed to provide a safe, sanitary and comfortable environment and prevent the	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 79 development and transmission of disease and infection when staff failed to properly sanitize a resident's room. Findings included: - On 1/22/15 at 8:21 AM, housekeeping staff X cleaned a resident ' s room on one of the three hallways. Staff X failed to clean and sanitize doorknobs, light switches, call light and other frequently touched surfaces. On 1/22/15 at 8:58 AM, housekeeping staff X revealed that the doorknobs, light switches and call lights are done monthly. The facilities undated Resident Room Cleaning Procedures policy revealed that on a daily basis surfaces to be cleaned included wall smudges, light switches, call switches, side tables, headboards/footboards/side rails of bed, windowsills and convection units. The facility failed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection when staff failed to clean frequently touched surfaces	F 441		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.	F 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

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F 520	Continued From page 80 The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: The facility reported a census of 32 residents. Based on interview and record review, the medical director did not participate in the quarterly Quality Assessment and Assurance (QAA) meeting 1 of 4 times in the last 12 months. Findings included: - Review of the facility provided sign in sheets the quarterly meeting on 7/23/14 lacked evidence the medical director attended the meeting. On 1/26/15 at 4:05 PM, Administrative nurse E confirmed the medical director did not attend the July Quality Assurance meeting. The facility failed to have a physician at their quarterly QAA meetings.	F 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
F W HUSTON MEDICAL CENTER	408 DELAWARE ST WINCHESTER, KS 66097

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE